Authorization for Release of Medical Records and Related Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Patient name: **Fejeran, Moses T, DOB 7-30-40** ID Number: **CHC # 10-33-19**

Persons/organizations authorized to provide the information: **CHC**

Persons/organizations authorized to receive the information: **Carlsmith Ball LLP, Attorneys, and David P. Ledger, Attorney.**

Specific description of information to be used or disclosed (including date(s)): **Regarding only treatment rendered to treat the right leg, and inparticular the right knee, and/or ankle and/or hip, all medical records, including x-ray films, fluoroscope films, and MRI imaging of the right knee.**

Specific purpose of the disclosure: **Assessment of the injury by other physicians.**

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No ___X_____ Yes (describe) _____

This authorization will expire: **Upon disclosure of the medical records identified above.**

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurance from the above-named persons/organizations

EXHIBIT "A"

authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Patient or Patient's Representative

[redacted] 8/4/06

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____

[redacted]